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Office of Administrative Law Judges
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Issue Date: 29 April 2005

In the Matter of:
FRANK MCCOY
Claimant

Case No.: 2003 BLA 271

v.

VIRGINA CREWS COAL COMPANY/
WEST VIRGINIA CWP FUND
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Ron Carson, Personal Representative
For Claimant

Mr. Robert Weinberger, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER --
APPROVAL OF MODIFICATION REQUEST
MATERIAL CHANGE IN CONDITIONS
DENIAL OF BENEFITS

This matter involves a claim filed by Mr. Frank McCoy for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim

Mr. McCoy filed his first application for black lung disability benefits on November 1, 1994 (DX 1).[1] After a pulmonary evaluation, a claims examiner for the U.S. Department of Labor ("DOL") denied his claim for benefits on May 1, 1995 because Mr. McCoy failed to prove the presence of pneumoconiosis or total disability.

Second Claim

On August 26, 1996, Mr. McCoy filed his second claim (DX 2). Following DOL's denial of the claim in December 1996 for failure to prove total disability, Mr. McCoy requested a hearing with the Office of Administrative Law Judge ("OALJ"). Subsequently, in May 1997, Mr. McCoy advised DOL that he no longer intended to pursue his claim for benefits at that time.

Third Claim

Initial Adjudication

On October 27, 1998, Mr. McCoy filed his third claim for black lung disability benefits (DX 3) On February 3, 1999, his claim was denied for failure to prove either the presence of pneumoconiosis or total disability (DX 15). A month later, Mr. McCoy appealed the adverse decision (DX 17). After considering additional evidence, on August 26, 1999, the District Director, DOL, again denied Mr. McCoy's claim because he failed to prove the presence of pneumoconiosis or total disability (DX 28).

First Modification Request

On August 14, 2000, Mr. McCoy submitted a pulmonary function test to support a request for modification of the denial decision (DX 29). Because the study did not meet the regulatory quality standard, the District Director determined the pulmonary function test did not support a finding of total disability (DX 31). As a result, the modification was denied. On September 11, 2000, Mr. McCoy appealed and requested a hearing with OALJ (DX 32). The District Director forwarded the case to the OALJ on December 18, 2000 (DX 33).

First Administrative Law Judge Proceeding

After conducting a hearing in May 2001, Administrative Law Judge Edward T. Miller denied Mr. McCoy's claim on September 27, 2001 (DX 42 and DX 44). Judge Miller determined that Mr. McCoy had not proven the requisite mistake of fact or change in condition to warrant modification of the denial of his third claim because the evidence did not establish the presence of pneumoconiosis or total respiratory disability. On October 1, 2001, Mr. McCoy appealed the denial of his modification request (DX 45).

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Benefits Review Board Determination

On July 16, 2002, the Benefits Review Board affirmed Judge Miller's findings that the evidentiary record established neither the presence of pneumoconiosis nor total disability (DX 49).

Second Modification Request

On November 11, 2002, Mr. McCoy submitted another modification request supported by a pulmonary function test and a chest x-ray interpretation indicating the presence of complicated pneumoconiosis (DX 53). The Employer responded by providing two negative interpretations of the new chest x-ray and noting the pulmonary function test did not establish total disability (DX 55). On June 4, 2003, the District Director forwarded the case to OALJ for resolution of the modification request.

Second, and Present, Administrative Law Judge Proceeding

Pursuant to a revised notice of hearing, dated January 6, 2004 (ALJ II), I conducted a hearing on February 11, 2004 in Princeton, West Virginia. Mr. McCoy, Mr. Carson and Mr. Weinberger were present at the hearing.

Evidentiary Discussion

Because Mr. McCoy's representative had not presented copies of CX 1 to CX 3 to Employer's counsel at least 20 days prior to the hearing, I gave Mr. Weinberger an opportunity to provide evidence in response post-hearing (TR, page 13). On March 12, 2004, I received an interpretation by Dr. Binns of an April 7, 2003 chest x-ray, marked as EX 1. At this time, I admit EX 1 into evidence. Accordingly, my decision in the case is based on the documents admitted into evidence: DX 1 to DX 59, CX 1 to CX 3, and EX 1.

ISSUES

1. Whether in filing a request for modification on November 11, 2003, Mr. McCoy has demonstrated that either: a) a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his first modification request was based; or, b) a mistake in determination of fact occurred in Administrative Law Judge Miller's September 2001 adjudication, as affirmed by the Benefits Review Board in July 2002.

2. If Mr. McCoy establishes a change in one of the applicable conditions of entitlement or a mistake in determination of fact, whether he has further established a material change in conditions since the denial of his most recent prior claim in 1996.

3 If Mr. McCoy establishes a material change in conditions, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the February 2004 hearing, the parties stipulated that Mr. McCoy had 32 years of coal mine employment; b) Mrs. Irma McCoy is a dependent for the purpose of augmenting any benefits that may be payable under the Act; and, c) Virginia Crews Coal Company is the responsible operator (TR, pages 8 to 10).

Preliminary Findings

Born on October 18, 1934, Mr. McCoy married Mrs. Irma McCoy on February 1, 1960. Mr. McCoy started his career in coal mining in 1953, working as a coal loader. Over the course of years in the coal mines, Mr. McCoy was also a cutting operator and pin machine operator. During his last twelve years of coal mining, Mr. McCoy was a roof bolter. As a roof bolter, Mr. McCoy engaged in occasional heavy labor when he had to force glue roof bolts into the mine's ceiling. His work also required him to lift 40 to 50 pound bags. He stopped mining coal in September 1991 when the coal mine shut down. At that time, Mr. McCoy's breathing was getting bad and he had back problems. Mr. McCoy started smoking cigarettes when he was "pretty young." At the time of the 2001 hearing, he was still smoking cigarettes at the rate of 3/4 of a pack a day (DX 1, DX, 2, DX 3, DX 9, DX 11, DX 31, and DX 42).

Issue # 1 – Modification

Any party to a proceeding may request modification at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310 (a).[2] Upon the showing of a "change in conditions" or a "mistake in a determination of fact," the terms of an award or the decision to deny benefits may be reconsidered. 20 C.F.R. § 725.310. An order issued at the conclusion of a modification proceeding may terminate, continue, reinstate, increase or decrease benefit payments or award benefits.

According to the courts and BRB, the phrase "change in conditions" refers to a change in a claimant's physical condition. See *General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982) and *Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*). Under the regulatory provisions, to determine whether a claimant demonstrates a change in conditions, an administrative law judge ("ALJ") must first conduct an independent assessment of all newly submitted evidence. Then, the ALJ must consider this new evidence in conjunction with all evidence in the official U.S. Department of Labor record to determine if the weight of the evidence is sufficient to establish an element of entitlement which was previously adjudicated against the claimant. K*ingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993);

[2]In January 2001, a new set of DOL regulations concerning the adjudication of black lung claims became effective. Only some portions of the new regulations are applicable to Mr. McCoy's modification request since it relates to a claim that was not finally denied more than one year prior to January 2001; such applicable provisions will be designated with "(2001)" as a suffix. (*see* 20 C.F.R. § 725.2 (c) (2001)).

Kovac v. BCNR Mining Corp., 14 B.L.R. 1-156 (1990), *aff'd. on reconsideration*, 16 B.L.R. 1-71 (1992).

The modification process has been further expanded by the United States Supreme Court and federal Courts of Appeals when they considered cases involving the mistake of fact factor listed in the regulations. In *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), the United States Supreme Court indicated that an ALJ should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the ALJ is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *See also Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Director, OWCP v. Drummond Coal Co. (Cornelius)*, 831 F.2d 240 (11th Cir. 1987).

My determination of whether either a change in condition has developed or a mistake of fact occurred involves the four entitlement elements that a claimant must prove by a preponderance of the evidence to receive benefits under the Act. First, the coal miner must establish the presence of pneumoconiosis.[3] Second, if a determination has been made that a coal miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.[4] If a coal miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[5] Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.[6] Third, the coal miner must demonstrate total respiratory disability.[7] Fourth, the coal miner must prove the total disability is due to coal workers' pneumoconiosis.[8]

In the affirmed denial of Mr. McCoy's first modification request, concerning both the presence of pneumoconiosis and total disability, Judge Miller determined that Mr. McCoy had failed to demonstrate either a change in condition since the denial of his second claim by the District Director in 1996 or a mistake of fact during that adjudication. In light of those findings, I must first evaluate whether Mr. McCoy is able to demonstrate a change of conditions through new evidence developed since the record closed before Judge Miller in 2001 by showing he now has pneumoconiosis or became totally disabled due to a pulmonary impairment. Secondly, I will consider the entire evidentiary record to determine whether a mistake of fact has occurred in the determination that Mr. McCoy does not have pneumoconiosis and is not totally disabled.

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[3]20 C.F.R. §718.202 (2001).

[4]20 C.F.R. §718.203 (a) (2001).

[5]20 C.F.R. §718.203 (b) (2001).

[6]20 C.F.R. §718.203 (c) (2001).

[7]20 C.F.R. §718.204 (a) (2001).

[8]*Id.*

Change in Condition

Under the change of conditions analysis, I must examine the medical evidence presented since Judge Miller closed the evidentiary record upon conclusion of his hearing in May 2001 to determine whether Mr. McCoy has developed pneumoconiosis or become totally disabled.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[9] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[10] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[11] As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202 (2001), the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1) (2001)), autopsy or biopsy report (§ 718.202 (a)(2) (2001)), regulatory presumption (§ 718.202 (a)(3) (2001)),[12] and medical opinion (§ 718.202 (a)(4) (2001)). With his second modification request, Mr. McCoy has not submitted a biopsy report; and, the record obviously does not contain an autopsy report. Additionally, the newly submitted evidence does not include any diagnosis by a physician based on a medical evaluation. As a result, Mr. McCoy will have to rely on the chest x-ray evidence to establish the presence of pneumoconiosis or complicated pneumoconiosis.[13]

[9]20 C.F.R. § 718.201 (a) (2001).

[10]20 C.F.R. §§ 718.201 (a)(1) and (2) (2001).

[11]20 C.F.R. § 718.201 (b) (2001).

[12]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3) (2001), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (2001) (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (2001) (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (2001) (a presumption when a survivor files a claim prior to June 30, 1982).

[13]According to the court in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), in determining whether a miner has pneumoconiosis, I must consider all the medical evidence together. In regards to Mr. McCoy's modification request, since the pulmonary tests do not establish etiology of any pulmonary impairment and no medical opinion, other than chest x-ray interpretations, has been developed during this modification period, my review of the radiographic evidence satisfies the *Compton* mandate.

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
April 2, 2002	DX 53	Dr. Ahmed, BCR, B[14]	Positive for pneumoconiosis, profusion 2/1,[15] type p opacities,[16] category B large opacity of complicated pneumoconiosis; emphysema present.
(same)	DX 55	Dr. Navani, BCR, B	Negative for pneumoconiosis, profusion 0/1, type t/r opacities, no large opacity; emphysema present.
(same)	DX 55	Dr. Binns, BCR, B	Negative for pneumoconiosis, profusion 0/1, type r/s opacities; no large opacity; emphysema present.
April 7, 2003	CX 1	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 1/2, type p/t opacities; 30 millimeter density in left upper lobe, possibly complicated pneumoconiosis.
(same)	EX 1	Dr. Binns, BCR, B	Positive for pneumoconiosis, profusion 1/0, type p/s opacities; no large opacity; pleural based density or artifact left chest wall.

Although Dr. Ahmed diagnosed the presence of pneumoconiosis in the April 2, 2002 chest x-ray, the profusion findings of 0/1 by Dr. Navani and Dr. Binns are insufficient under the regulation to establish the presence of pneumoconiosis (*see* 20 C.F.R. § 718.102 (b) (2001)). Since all three radiologists have the same high qualifications, I find the consensus of Dr. Navani and Dr. Binns establishes that the April 2, 2002 chest x-ray is negative for pneumoconiosis.

A year later, upon evaluation of the April 7, 2003 film, Dr. Alexander and Dr. Binns agreed that the x-ray is positive for the presence of pneumoconiosis. Their consensus establishes that the April 7, 2003 is positive for pneumoconiosis.

[14]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii) (2001).

[15]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b) (2001), a profusion reading of 0/1 does <u>not</u> constitute evidence of pneumoconiosis.

[16]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

Initially, the two recent chest x-rays associated with the modification request, one negative and one positive, seems to be in evidentiary equipoise and consequently inconclusive. However, for four, related reasons, I find that this radiographic evidence establishes that by April 7, 2003, Mr. McCoy's borderline pneumoconiosis had progressed to the requisite profusion level of 1 to support the radiologists' consensus that the film was positive for pneumoconiosis.

First, though Dr. Navani and Dr. Binns ultimately concluded the April 2002 film was negative, their profusion reading of 0/1 indicates both doctors initially considered that the profusion level might be level 1, such that the film would be positive for pneumoconiosis. Though both radiologists finally concluded the profusion level was insufficient for a pneumoconiosis diagnosis, their separate deliberations, coupled with Dr. Ahmed's positive finding, indicates the April 2002 chest x-ray was a borderline film, almost establishing the presence of pneumoconiosis.

Second, as the existence of a change of condition adjudication principle demonstrates, coal workers' pneumoconiosis is considered to be a progressive disease. This principle has been long enunciated in judicial and Benefit Review Board decisions[17] and recently confirmed with its inclusion in the new version of the 2001 regulations. Specifically, 20 C.F.R. § 718.201 (c) (2001) states that pneumoconiosis "is recognized as a latent and progressive disease. . ."

Third, since the two x-rays were taken a year apart, they are not contemporaneous radiographic studies. In other words, I consider the one year separation between the April 2002 chest x-ray and April 2003 radiographic study to be sufficient to permit consideration that black lung disease progressed in Mr. McCoy's lungs.

Fourth, as the only radiologist to consider both chest x-rays, Dr. Binns was in an excellent position to note the development of any pneumoconiosis opacities. His two interpretations show that the pulmonary opacities in the April 2002 chest x-ray which he found insufficient for a pneumoconiosis diagnosis developed in profusion over the course of one year to the extent Dr. Binns subsequently diagnosed pneumoconiosis in the April 2003 film.

Accordingly, in light of these factors and since the most recent chest x-ray is positive for pneumoconiosis, I find that Mr. McCoy has proven the existence of pneumoconiosis under 20 C.F.R § 718.202 (a)(1) (2001).

The development of pneumoconiosis in Mr. McCoy's lungs by April 2003 represents a change in condition since Judge Miller's denial of his first modification request which warrants modification of that denial. As a result, based on the modification of the denial of the first modification request, I conclude that a review of all the medical evidence developed since the denial of Mr. McCoy's second claim in 1996 is warranted to determine whether Mr. McCoy has also proven a material change in conditions.

[17] *See Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989) (*en banc*).

Issue # 2 – Material Change in Condition

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. *See* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a duplicate claim which will be denied unless the claimant demonstrates a material change in conditions under the provisions of 20 C.F.R. § 725.309, as interpreted by the Benefits Review Board and federal Courts of Appeals. Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

The Court of Appeals for the Fourth Circuit, which has jurisdiction over this claim, has followed the Sharondale approach. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd* 86 F.3d 1358 (4th Cir. 1996)(*en banc*). I interpret the *Sharondale* approach to mean that the relevant inquiry in a material change case is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In determining whether there has been a material change in condition, I again return to the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act: the presence of pneumoconiosis, pneumoconiosis due, at least in part, to coal mine employment, totally disability, and total disability due to coal workers' pneumoconiosis.

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the only elements that are capable of changing are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total

disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. McCoy's case, his most recent, prior claim was denied in December 1996 for failure to prove total disability. Consequently, for purposes of adjudicating his present duplicate claim which he filed in October 1998, I will evaluate the evidence developed since 1996 to determine whether Mr. McCoy can now prove the presence of a total respiratory disability.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304 (2001). If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Director, OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

In Mr. McCoy's case, no evidence of cor pulmonale has been presented. As a result, Mr. McCoy must rely on the presence of complicated pneumoconiosis, pulmonary function tests, arterial blood gas studies, or medical opinion to establish that he has developed a totally disabling pulmonary impairment since the denial of his second claim in 1996.

Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304 (a) (2001), provides an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis if the miner suffered from a chronic dust disease of the lungs which: "when diagnosed by chest x-ray. . .yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C. . ." The radiographic evidence developed since 1996 is set out below:

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
January 6, 1999	DX 13	Forehand, B	Negative for pneumoconiosis; bilateral pleural scarring present
(same)	DX 14	Cole, BCR, B	Completely negative
(same)	DX 24 & DX 26	Meyer, BCR, B	Negative for pneumoconiosis; ill defined nodule present right side, front second rib.
(same)	DX 25	Wiot, BCR B	Negative for pneumoconiosis; emphysema present.
August 10, 2000	DX 39	Alexander, BCR, B	Positive for pneumoconiosis, profusion 1/2, type q/p opacities; "possible 10 mm pulmonary nodule right upper lung."
December 15, 2000	DX 34	Forehand, B	Negative for pneumoconiosis.
April 2, 2002	DX 53	Ahmed, BCR, B	Positive for pneumoconiosis, profusion 2/1, type p opacities, category B large opacity of complicated pneumoconiosis; emphysema present.
(same)	DX 55	Navani, BCR, B	Negative for pneumoconiosis, profusion 0/1, type t/r opacities, no large opacity; emphysema present.
(same)	DX 55	Binns, BCR, B	Negative for pneumoconiosis, profusion 0/1, type r/s opacities; no large opacity; emphysema present.
April 7, 2003	CX 1	Alexander, BCR, B	Positive for pneumoconiosis, profusion 1/2, type p/t opacities; 30 millimeter density or thickening in "left" upper lobe, possibly complicated pneumoconiosis.
(same)	EX 1	Binns, BCR, B	Positive for pneumoconiosis, profusion 1/0, type p/s opacities; no large opacity; pleural based density or artifact left chest wall.

Three chest x-rays, August 10, 2000, April 2, 2002, and April 7, 2003, raise the possibility that Mr. McCoy has complicated pneumoconiosis. In the August 10, 2000 radiographic study, Dr. Alexander identified a "possible" 10 mm pulmonary nodule in the right upper lobe. However, that interpretation does not establish the presence of complicated pneumoconiosis for two reasons. First, Dr. Alexander's use of the term "possible" renders his diagnosis equivocal.[18] Second, and more important, Dr. Alexander's finding is one millimeter too small to qualify as complicated pneumoconiosis. As previously stated, complicated pneumoconiosis is defined as a large radiographic opacity greater than one centimeter (10 millimeters).

The other two, most recent chest x-rays raised a dispute among the medical experts who evaluated the films concerning the existence of complicated pneumoconiosis. Dr. Ahmed's observation of a Category B, large opacity in the April 2, 2002 film fits the definition of complicated pneumoconiosis. However, during their review of the same chest x-ray, neither Dr. Navani nor Dr. Binns saw any large opacity. The consensus of Dr. Navani and Dr. Binns represents the preponderance of the interpretations of the April 2, 2002. In light of the preponderance of the interpretations, I conclude the April 2, 2002 chest x-ray does not establish the presence of complicated pneumoconiosis.

[18] *See Island Creek Coal Co. v. Holdman,* 202 F.3d 873 (6th Cir. 2000).

In the April 7, 2003 chest x-ray, Dr. Alexander saw a "possible" 30 millimeter opacity. Although the size of the density meets the regulatory definition of complicated pneumoconiosis, his use of the term "possible" renders his assessment equivocal. While Dr. Binns saw a density in the chest wall, he did not find a large pulmonary opacity. Based on these contrasting interpretations by similarly well qualified radiologists, I find their medical opinion standoff renders the April 7, 2003 chest x-ray inconclusive for the presence of complicated pneumoconiosis.

Due to the insufficiency of the August 10, 2000 radiographic interpretation, the preponderance of the interpretations for the April 2, 2002 chest x-rays indicating the absence of a large pulmonary opacity, and the inconclusive nature of the April 7, 2003 film, I conclude Mr. McCoy is not able to establish total disability due to the presence of complicated pneumoconiosis under 20 C.F.R. § 718.304 (2001).

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[19] post[20]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[21] pre Post**	**Comments**
DX 10	January 6, 1999 Dr. Forehand	64 69"	2.58	4.44	72	58%	No[22]	Normal
DX 26	March 29, 1999 (name illegible)	64 71"	2.09	4.65		45%	No[23]	Moderate obstruction[24]
DX 29	March 15, 2000 (name illegible)	65 71"	1.72	3.97		43"	Yes[25]	Moderate obstruction[26]

[19]Test result before administration of a bronchodilator.

[20]Test result following administration of a bronchodilator.

[21]Under 20 C.F.R. § 718.204 (b) (2) (i) (2001), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[22] The qualifying FEV1 number is 1.90 for age 64 and 69″; the corresponding qualifying FVC and MVV values are 2.44 and 76, respectively.

[23]The qualifying FEV1 number is 2.06 for age 64 and 71″; the corresponding qualifying FVC and MVV values are 2.63 and 83 respectively.

[24]Although the administering registered nurse indicated Mr. McCoy's was cooperative and his effort was good, Dr. Ranavaya found the test to be unacceptable due to less than optimal effort (DX 27).

[25]The qualifying FEV1 number is 2.04 for age 65 and 71″; the corresponding qualifying FVC and MVV values are 2.61 and 82 respectively.

[26]Once again, the administering nurse reported good cooperation and effort. However, based on the tracings, Dr. Gaziano determined the test was invalid due to variance and poor effort on the FEV portion of the evaluation (DX 30).

DX 34	December 15, 2000 Dr. Vasudevan	66 71"	1.57 1.77	3.59 4.64	64 72	44% 36%	Yes[27]	Severe reduction in FEV1
DX 53	March 12, 2002 (name illegible)	67 71"	2.31	4.61		51%	No[28]	Moderate obstruction
CX 2	January 6, 2004 Dr. Narayanan	69 71"	1.73	3.58		48%	Yes[29]	Moderately severe obstruction

The six pulmonary function tests present a conflicting picture as to whether Mr. McCoy has a totally disabling respiratory impairment. Under the provisions of 20 C.F.R. § 718.204 (b) (2) (i) (2001), if the preponderance of pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary tests shall establish a miner's total disability. This regulatory scheme requires a five step process. First, an administrative law judge must determine whether the tests conform to the procedural requirements in 20 C.F.R. § 718.103 (2001). Second, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. *See Vivian v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990). At the same time, more weight may be given to the observations of technicians who administered the tests than the doctor who reviewed the tracings. *Revnack v. Director, OWCP*, 7 B.L.R. 1-771 (1985). If an administrative law judge credits the reviewing doctor's opinion over the technician who actually observed the test, he must provide a rationale. *Brinkley v. Peabody Co*., 14 B.L.R. 1-147 (1990). Third, the test results are compared to the qualifying numbers listed in Appendix B to determine whether the tests show total disability. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. In that regard, more probative weight may be given to the results of a more recent study over those of an earlier test. *Coleman v. Ramey Coal Co*., 18 B.L.R. 1-9 (1993). Fifth, if the preponderance of conforming tests establishes total disability under the regulation, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, it must be given appropriate evidentiary weight and a determination is then made to see if it outweighs the pulmonary function test evidence that supports a finding of total respiratory disability. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-21 (1987).

In Mr. McCoy's case, all six tests appear to satisfy procedural requirements. Next, the validity of the March 1999 and March 2000 tests have been challenged. Based on his review of the March 1999 study, despite the report of good effort by the administering technician, Dr. Ranavaya believed the test was invalid due to Mr. McCoy's less than optimal effort. However, notably, Dr. Ranavaya did not identify the specific characteristic of the tracings that raised his

[27]The qualifying FEV1 number is 2.03 for age 66 and 71″; the corresponding qualifying FVC and MVV values are 2.60 and 81 respectively.

[28]The qualifying FEV1 number is 2.01 for age 67 and 71″; the corresponding qualifying FVC and MVV values are 2.58 and 80 respectively.

[29]The qualifying FEV1 number is 1.98 for age 69 and 71″; the corresponding qualifying FVC and MVV values are 2.54 and 79 respectively.

concern. In the absence of such specificity, I give his conclusion less probative weight than the technician's observation of good effort by Mr. McCoy. As a result, I believe the March 29, 1999 pulmonary function test was valid.

In contrast, Dr. Gaziano identified variance in FEV_1 line tracings for the March 15, 2000 test as the reason he concluded Mr. McCoy's effort was not optimal. Due to the specificity of his comments, I give Dr. Gaziano's report greater probative weight over the conclusions of the administering technician. As a result, the March 2000 pulmonary function test is invalid.

Of the five valid pulmonary function tests, only two of the studies, December 15, 2000 and January 6, 2004, met the regulatory qualifications for total disability. However, the pattern of the test results shows a general decline in pulmonary function from 1999 to 2004 to the extent that I find the last pulmonary function test of January 2004 has the greatest probative value. Based on that most recent study, absent evidence to the contrary, Mr. McCoy may be able to establish total disability through pulmonary function test evidence.

Other Medical Evidence

As the final step in determining whether the preponderance of the most recent pulmonary function test in January 2004 establishes total disability, I must consider other evidence that may be contrary and render a probative value assessment.

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest)** **pCO^2 (exercise)**	**pO^2 (rest)** **pO^2 (exercise)**	**Qualified**[30]	**Comments**
DX 12	January 6, 1999 Dr. Forehand	37 37	67 69	No[31] No	Normal
DX 34	December 15, 2000 Dr. Vasudevan	38.2 38	69 66	No[32] No	

Though neither blood gas study satisfied the regulatory total disability criteria, Dr. Vasudevan nevertheless indicated that the December 2000 evaluation showed mild to moderate hypoxemia. Additionally, since the pulmonary function tests and arterial blood gas studies measure two different aspects of pulmonary capacity, the non-qualifying arterial blood gas studies, standing alone, do not preclude a finding of total disability based on pulmonary function tests.

[30]Under 20 C.F.R. § 718.204 (b) (2) (ii) (2001), to qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[31]For a pCO^2 of 37, the qualifying pO^2 is 63, or less.

[32]For a pCO^2 of 38, the qualifying pO^2 is 62, or less.

Medical Opinion

When determining whether the medical opinion developed since the denial of Mr. McCoy's second claim in 1996 represents contrary evidence, I also consider that according to 20 C.F.R. § 718.204 (b) (2) (iv) (2001), total disability may be found:

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b) of this section.

The regulation, 20 C.F.R. § 718.204 (b) (1) (2001) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. Thus, to evaluate total disability under these provisions, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of his respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Based on Mr. McCoy's testimony that his job as a roof bolter occasionally required lifting 40 to 50 pound bags and heavy exertion when applying glue bolts, I find he engaged in heavy manual labor during his last employment in the coal mines as a roof bolter. With that physical requirement in mind, I turn to the opinion of the physicians who evaluated Mr. McCoy's pulmonary condition since 1996.

Dr. J. Randolph Forehand
(DX 11)

On January 6, 1999, Dr. Forehand conducted a pulmonary evaluation of Mr. McCoy. Mr. McCoy had 38 years of coal mine employment. He started smoking cigarettes in the 1950s and was still smoking at the time of the examination at the rate of 3/4 packs of cigarettes a day. Mr. McCoy indicated that he was persistently short of breath and his condition worsened upon exertion. During the physical examination, Dr. Forehand heard normal breath sounds. The chest x-ray was negative for pneumoconiosis. Both the pulmonary function test and arterial blood gas study were normal. Based on his evaluation, Dr. Forehand concluded Mr. McCoy did not have coal workers' pneumoconiosis and he was not totally disabled.

Dr. Cuddalore Vasudevan
(DX 34)

On December 15, 2000, Dr. Vasudevan, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation. Mr. McCoy claimed 38 years of coal mine employment with a wide range of jobs, including roof bolter. He had also smoked cigarettes for 50 years at the rate of one pack of cigarettes a day. Mr. McCoy was experiencing wheezing and chronic shortness of breath with exercise. The physical examination disclosed distant breath sounds. The chest x-ray was negative for pneumoconiosis and the arterial blood gas study revealed mild to moderate hypoxemia. The pulmonary function test showed "a severe reduction

in exercise capacity due to a ventilation limitation." Dr. Vasudevan concluded that although Mr. McCoy did not have coal workers' pneumoconiosis, he had a moderately severe chronic obstructive airways disease.

Dr. E. B Whitely
(CX 4)

On January 8, 2004, Dr. Whitely reported that a test of Mr. McCoy for tuberculosis was negative.

Discussion

Although Dr. Vasudevan did not specifically state that Mr. McCoy was unable to return to coal mining, his conclusion that Mr. McCoy had a moderately severe obstructive pulmonary impairment supports a finding of total disability because Mr. McCoy's work as a roof bolter involved heavy labor. Dr. Forehand did not find Mr. McCoy to be totally disabled. However, his assessment has diminished probative valued because he relied in part on the non-qualifying pulmonary function test conducted in 1999. In other words, Dr. Forehand's 1999 assessment does not impeach my determination that the January 2004 pulmonary function study establishes total disability.

Since neither the arterial blood gas studies nor the medical opinion represents sufficient contrary evidence, I find that Mr. McCoy has established a total pulmonary impairment under 20 C.F.R. § 718.204 (b) (2) (i) (2001) through pulmonary function tests. In turn, this determination means Mr. McCoy has become totally disabled due to a respiratory impairment since the denial of his second claim in 1996, which establishes the requisite material change in condition under 20 C.F.R. § 718.309. According to 20 C.F.R. § 718.309, since Mr. McCoy has established a material change in conditions, I must next consider the entire record to determine whether he is entitled to black lung disability benefits.

Issue # 3 – Entitlement to Benefits

To review, to establish his entitlement to black lung disability benefits, Mr. McCoy must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

Pneumoconiosis

Considering the evidence in the entire record, Mr. McCoy may prove pneumoconiosis through chest x-rays or medical opinion. Additionally, under the guidance of the *Compton* court, I must consider the entire evidentiary record together prior to making a determination about pneumoconiosis.

Additional Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
December 2, 1994	DX 1	Hickey, BCR, B	Negative for pneumoconiosis; chronic bronchitis present.
(same)	DX 1	Gaziano, B	Negative for pneumoconiosis; possible old healed tuberculosis present.
September 13, 1996	DX 2	Ranavaya, B.	Positive for pneumoconiosis, profusion 1/1, type p opacities.
(same)	DX 2	Gaziano, B	Positive for pneumoconiosis, profusion 1/0; type t opacities.
(same)	DX 2	Shipley, BCR, B	Completely negative.
(same)	DX 2	Spitz, BCR, B	Completely negative.
(same)	DX 2	Wiot, BCR, B	Negative for pneumoconiosis; old pleural disease left apex.

Based on the consensus of the two physicians, the December 2, 1994 chest x-ray is negative for pneumoconiosis. A medical dispute arose concerning the September 13, 1996 film. Dr. Ranavaya and Dr. Gaziano saw pneumoconiosis. Dr. Shipley, Dr. Spitz, and Dr. Wiot did not. Since the later three doctor are dual qualified radiologists, I give their assessments greater probative value. Based on that more probative consensus, I find the January 13, 1996 chest x-ray is negative for pneumoconiosis.

While consideration of the entire record draws in the negative chest x-rays from Mr. McCoy's two earlier claims, those two films do not alter my prior determination that the most recent chest x-ray of April 2003 establishes that Mr. McCoy has developed pneumoconiosis. Thus, under 20 C.F.R. § 718.202 (a) (1) (2001), Mr. McCoy remains able to prove the presence of pneumoconiosis through the most recent chest x-ray.

Compton Consideration

As previously discussed, the *Compton* guidance requires that I consider all the evidence together prior to making a determination about the presence of pneumoconiosis. That consideration includes the medical opinions previously summarized and the following two opinions presented in the earlier two claims.

Dr. C. Vasudevan
(DX 1)

On December 2, 1994, Dr. Vasudevan examined Mr. McCoy who had more than 20 years of coal mine employment. Mr. McCoy had also been smoking cigarettes for 20 years at the rate of 3/4 a pack a day. He reported chronic shortness of breath. The physical examination was normal and the chest x-ray was negative for pneumoconiosis. The pulmonary function test revealed a moderated airflow obstruction. The arterial blood gas study disclosed borderline hypoxemia. Dr. Vasudevan diagnosed COPD (chronic obstructive pulmonary disease) due to cigarette smoking. The physician also believed Mr. McCoy may have old, healed tuberculosis.

Dr. Mohammed Ranavaya
(DX 2)

On September 13, 1996, Dr. Ranavaya evaluated Mr. McCoy's pulmonary condition. Mr. McCoy had mined coal for 38 years and smoked 3/4 a pack of cigarettes a day for 26 years. Mr. McCoy reported shortness of breath, mostly on exertion. On examination, Dr. Ranavaya heard scattered wheezes. The chest x-ray was positive for pneumoconiosis. The arterial blood gas study was normal and the pulmonary function test indicated the presence of a mild impairment. Dr. Ranavaya diagnosed coal workers' pneumoconiosis and a mild pulmonary impairment due to coal workers' pneumoconiosis.

Discussion

In 1996, Dr. Ranavaya diagnosed pneumoconiosis. The other two physicians, Dr. Forehand and Dr. Vasudevan, to consider Mr. McCoy's condition did not find black lung disease. However, while the greater weight of the medical opinion demonstrates Mr. McCoy did not have pneumoconiosis through at least 2000, all the physicians made their conclusions prior to the April 2003 chest x-ray, upon which I made my determination that Mr. McCoy has developed pneumoconiosis. As a result, although the consensus of medical opinion shows Mr. McCoy did not have pneumoconiosis from 1994 to 2000, the medical opinion in the record does not outweigh my finding that the April 2003 chest x-ray establishes the presence of pneumoconiosis. Accordingly, having accomplished the *Compton* analysis, I again conclude that Mr. McCoy has proven that he has pneumoconiosis under 20 C.F.R. § 718.202 (a) (1) (2001).

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. McCoy must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. §718.203 (b) (2001), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. Since the parties have stipulated that Mr. McCoy has at least 32 years of coal mine employment, he is entitled to the regulatory presumption.

Because the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, I must reexamine the medical record to determine whether sufficient evidence exists to sever the presumptive connection between Mr. McCoy's pneumoconiosis and his coal mine employment. In terms of rebuttal evidence, since Dr. Forehand essentially did not find any pulmonary disease, his assessment has little probative value in determining whether the pneumoconiosis established by the most recent chest x-ray is caused by coal mine employment. Similarly, Dr. Vasudevan also concluded prior to the most recent chest x-ray that Mr. McCoy did not have pneumoconiosis. As a result, his opinion also does not rebut the invoked presumption that Mr. McCoy's newly developed pneumoconiosis is due to his coal mining. Consequently, I find Mr. McCoy has coal workers' pneumoconiosis.

Total Disability

Returning to the issue of total pulmonary disability, I conclude due to their dated nature that the following pulmonary function tests and arterial blood gas studies, with the associated opinions of Dr. Vasudevan and Dr. Ranavaya, do not represent sufficient contrary evidence to a determination of total disability based on the January 2004 pulmonary function test results. In fact, the history of pulmonary test results record the deterioration of pulmonary function capacity Mr. McCoy has experienced between 1994 and 2004. Accordingly, I find Mr. McCoy has proved total disability under 20 C.F.R. § 718.204 (b) (2) (i) (2001).

Additional Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre post	FVC pre post	MVV pre post	% FEV¹ / FVC pre post	Qualified pre Post	Comments
DX 1	December 2, 1994 Dr. Vasudevan	60 71"	3.02 3.03	5.71 5.50	87 91	56% 55%	No[33] No	
DX 2	September 13, 1996 Dr. Ranavaya	6171"	2.73 2.84	4.89 4.76	80 67.5	56% 60%	No[34] No	

Additional Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified	Comments
DX 1	December 2, 1994 Dr. Vasudevan	37.6 37.9	79 77	No No	
DX 2	September 13, 1996 Dr. Ranavaya	44	78	No[35]	

Total Disability Due to Coal Workers' Pneumoconiosis

Because Mr. McCoy has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Instead, a claimant must prove that coal workers' pneumoconiosis is at least a contributing cause of his pulmonary impairment. *Milburn Colliery Co v. Hicks,* 138 F. 3d 524, 535 (4th Cir. 1998) and *Scott v.*

[33]The qualifying FEV1 number is 2.12 for age 60 and 71″; the corresponding qualifying FVC and MVV values are 2.44 and 85, respectively.

[34]The qualifying FEV1 number is 2.11for age 61and 71″; the corresponding qualifying FVC and MVV values are 2.68 and 84 respectively.

[35]For a pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

Mason Coal Co., 14 B.L.R 1-37 (1990) (*en banc*). This determination is particularly important when more than one possible cause exists for the pulmonary impairment.

Title 20 C.F.R. § 718.204 (c) (1) (2001) states that absent regulatory presumption in favor of a claimant, the claimant must demonstrate that coal workers' pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204 (c) (1) (2001) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned report."

Mr. McCoy has been exposed to at least two principle pulmonary irritants. Throughout the course of at least 32 years of coal mine employment, he worked in an environment of coal dust. Also, throughout most of his adult life, at the rate of three-fourths to one pack a day, Mr. McCoy has inhaled cigarette smoke into his lungs.

In determining the interrelationship between these two pulmonary irritants and Mr. McCoy's pulmonary impairment, I am confronted with a dearth of current medical opinion on whether Mr. McCoy is totally disabled due to coal workers' pneumoconiosis. Given the procedural history of this case and my determinations that Mr. McCoy has developed pneumoconiosis and become totally disabled since 2002, this lack of probative medical evidence addressing the cause or causes of his current pulmonary impairment is understandable. For example, while Dr. Ranavaya in his September 1996 assessment associated a disabling impairment with coal workers' pneumoconiosis, he based his diagnosis on medical evidence that was insufficient at the time to warrant a finding of pneumoconiosis. Due to the dated nature of his evaluation, Dr. Ranavaya obviously did not consider the more recent medical evidence before me that led to my conclusions that Mr. McCoy has coal workers' pneumoconiosis and is totally disabled. Due to the requirement in 20 C.F.R. § 718.204 (c) (1) (2001), as the claimant in this case, Mr. McCoy bears the burden of proving <u>through medical opinion</u> that his coal workers' pneumoconiosis was a significant contributing factor in his development of a pulmonary impairment. In the record before me, he has failed to do so.

CONCLUSION

Based on the most recent chest x-ray of April 2003, Mr. McCoy has established that a change in his condition has occurred since Judge Miller's denial of his most recent modification request. Upon reconsideration of his third claim, the evidence also demonstrates that Mr. McCoy has become totally disabled due to a pulmonary impairment since the denial of his second claim in 1996. Based on the evidence in the entire record, Mr. McCoy has proven that he has coal workers' pneumoconiosis and a totally disabling pulmonary impairment. However, Mr. McCoy has failed to prove that coal workers' pneumoconiosis was a significant contributing cause of his total disability. Accordingly, his claim for black lung disability benefits must be denied.

ORDER

The black lung disability benefits claim of MR. FRANK MCCOY is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: April 28, 2005
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481 (2001), any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 (2001) and § 725.479 (2001). A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.